	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155520	B. WIN			02/05/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
BRAUN'S	S NURSING HOME	ELLC			RST AVE VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
F0000							
			F00	00			
				00			
	This visit was fo	or the Investigation of					
	Complaint IN00	_					
	•						
	Complaint IN00	0123348 Substantiated,					
	Federal/State de	eficiencies related to the					
	allegations are o	cited at F157, F441, and					
	F514.						
	Survey date:						
	February 5, 201	3					
	Facility number	: 000437					
	Provider numbe	er: 155520					
	AIM number: 1	00273770					
	Survey team:						
	Anne Marie Cra	ıys RN					
	Census bed type	2:					
	NF: 39						
	SNF/NF: 14						
	Total: 53						
	Census payor ty	pe:					
	Medicaid: 47						
	Other: 6						
	Total: 53						
	Commiss 2						
	Sample: 3						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155520		(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIE S NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	These deficienc	ies reflect state findings nce with 410 IAC 16.2.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/05/2013	
		100020	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/00/2010	
NAME OF P	PROVIDER OR SUPPLIER			RST AVE		
BRAUN'S	NURSING HOME	LLC		SVILLE, IN 47710		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLI DAT	
F0157	483.10(b)(11)	LSC IDENTIFYING INFORMATION)	TAG	DEI CHENCT)	DAI	Е
SS=E	NOTIFY OF CHA (INJURY/DECLIN A facility must immore ident; consult of physician; and if he legal representation member when the resident which the potential for resident's physical status (i.e., a deteor psychosocial status (i.e., a deteor psychosocial status (i.e., a deteor psychosocial status (i.e., existing form of the consequences, of the facility must a specified in §483.	ME/ROOM, ETC) mediately inform the with the resident's known, notify the resident's ve or an interested family ere is an accident involving in results in injury and has equiring physician unificant change in the al, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an eatment due to adverse r to commence a new form a decision to transfer or ident from the facility as				
	when there is a cl roommate assign §483.15(e)(2); or under Federal or specified in parag The facility must r update the address	interested family member hange in room or ment as specified in a change in resident rights State law or regulations as graph (b)(1) of this section. Tecord and periodically and phone number of all representative or				
	interested family of Based on observed record review, the physicians of results and obtain treatments.		F0157	Plan of Correction Response F157 The facility has written clear and concise Policies and Procedures to address all area identified under F157. They a identified below: 1. F157	l as	/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLET	ED
		155520	B. WIN			02/05/20)13
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			RST AVE		
BRAUN'S	S NURSING HOME	LLC			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
		ements, for 3 of 3			483.10(b)(11) "Policy and Procedure - Change in a		
residents reviewed who were treated for				Resident's Condition or Status	,,		
	scabies, in a sam	pple of 3. Residents A, B,			2. F157 483.15(e)(2) "Policy		
	and C				Procedure – Change in a		
	Findings include:				Resident's Condition or Status 3. F157 483.15(b)(1) "Policy Procedure – Change in a Resident's Condition or Status	and	
	1. On 2/5/13 at 1	0:10 A.M., during			The Administration will in-serv		
	interview with th	ne Director of Nursing			and educate all professional		
		cated there had not been			nursing staff and appropriate		
	cases of scabies recently until				administrative personnel		
	approximately 1/16/13, when a staff				regarding the Policy and Procedure for a Change in a		
	1 1 1	served to have a rash. The			Resident's Condition or Status		
		she had a "house supply"			before February 18, 2013. In	I .	
		n cream. The DON			addition, the Administration ha		
					implemented a 24-hour Reside		
		edical Director informed			Condition Change Sheet. This		
	<u>-</u>	suspicious rashes on			form will be maintained by each	n	
		f with the Permethrin			Charge Nurse and will be delivered to the Director of		
	cream [an scabio	cidal ointment]. The DON			Nursing daily. The Director of		
	indicated she co	uld not say that residents'			Nursing will utilize this tool to		
	physicians or far	mily members had been			monitor compliance with		
	notified of the so	cabies or the treatment.			notification of changes. The		
					Director of Nursing, or their	_	
	The DON indica	ated at that time that the			designee, will follow-up in each resident's medical record on a		
		given her a list of			weekly basis for one month, or	I .	
		ad been treated for			monthly basis for a randomly	-	
		d on the list were			selected number from each ur	nit	
					for the next quarter, and on a		
	Residents A, B,	and C.			quarterly basis for a randomly		
	0.015110	20.4.16.1.:			selected number from each ur from this point forward to ensu	I .	
	On 2/5/13 at 11:	_			that we have notified the resid		
		ne Medical Director, he			their legal representative or far	· ·	
	indicated he was aware residents had been				member and physician of any	, l	
	treated for scabi	es, but was unaware of			change in the resident's medic		
	which residents.	The Medical Director			condition and/or status. Week	ly	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155520	B. WING			02/05/	2013
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ST AVE		
BRAUN'S	S NURSING HOME	LLC			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated scabie	s was "very contagious,"			"At Risk" meetings are held to		
	and residents an	d staff should be treated if		discuss any significa			
	there was a susp	icious rash.			the resident's medical condition and/or status. This meeting is		
	_				attended by the Assessment		
	On 2/5/13 at 1:5	5 P.M., the DON			Coordinator, Social Service		
		ent B was treated on			Director, Dietary Manager, Un		
		and 2/4/13; Residents A			Manager, Director of Nursing,		
	and C were treat	· ·			Administrator. The discussion		
	and C were treat	ou on 2/∃/13.			during this meeting will be utili as a means of identifying the	∠ c u	
	2 On 2/5/12 at (0.20 A.M. duning the			medical record of residents for		
		9:20 A.M., during the			audit purposes. The Director	of	
		# 1 indicated she thought			Nursing assumes responsibilit		
		been treated for scabies			for and ensures compliance. T	he	
	"last night."				Administrator is ultimately		
					responsible for overall compliance. The Policy and		
	On 2/5/13 at 10:	45 A.M., the clinical			Procedure for Change in a		
	record of Reside	ent C was reviewed.			Resident's Condition or Status	i	
	Diagnoses inclu	ded, but were not limited			and the 24-hour Resident		
	to, dementia. Do	ocumentation that the			Condition Change Sheet is		
	physician or fan	nily was notified of a rash			completed and will be available	е	
	or complaints of	itching, or receiving the			for review by the surveyor or survey team upon revisit.		
		it, was not located in the			Compliance Date: February 1	8.	
	clinical record.				2013 Margaret H. Braun, HI		
	Cimical record.				Administrator Braun's Nursing	1	
	On 2/5/13 at 11:	15 A M. a skin			Home		
		requested. CNA # 1					
		•					
		d just given the resident a					
		ning, because the resident					
		cream applied the night					
		C indicated, "It itches."					
		were observed on the					
	resident's right leg, left arm, and						
	abdomen. The ri	ght leg had scabbed					
	areas, where the	resident demonstrated					
	she had scratche	d.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00)	COMPL	
		155520	B. WING			02/05/	2013
NAME OF P	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
				FIRST A			
BRAUNS	S NURSING HOME	LLC	EVA	NSVILLE	E, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCI)		DATE
	2 0 2/5/12	222435 1 : 4					
3. On 2/5/13 at 9:20 A.M., during the							
initial tour, LPN # 1 indicated Resident							
	A had been treat	ed for scabies.					
		5 A.M., the clinical					
		nt A was reviewed.					
		ded, but were not limited					
	· ·	tia. Documentation that					
		family was notified of a					
	•	at of itching, or receiving					
		ment, was not located in					
	the clinical recor	⁻ d.					
	On 2/5/13 at 1:20	0 P.M., a skin assessment					
	was requested. R	Resident A indicated the					
	itching "comes a	and goes." Resident A					
	indicated both of	f her arms and abdomen					
	were the main pl	aces that itched.					
	Scattered rash-ty	pe areas were observed					
	on her bilateral a	arms and abdomen.					
	4. On 2/5/13 at 9	9:20 A.M., during the					
		# 1 indicated Resident B					
	had been treated						
	On 2/5/13 at 10:0	05 A.M., the clinical					
		nt B was reviewed.					
		ded, but were not limited					
	to, Alzheimer's d	•					
	,						
	A care nlan dat	ed 12/10/12, indicated:					
		ems, Alteration in skin:					
	Eczema"	onis, Anoranon in Skin.					
	Lozonia						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155520	B. WIN			02/05/	2013
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .		909 FIR	RST AVE		
	NURSING HOME	LLC		EVANS'	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	The most recent alteration in skin P.M., indicated, over D/T [due to [treatment] conts unsuccess [sic] Documentation notification of the complaints of ite physician's order in the clinical recomplaints or i	nursing note regarding an a, dated 12/25/12 at 1:00 "digs [and] scratches all of red rash on body. Tx is [continues] [with]" of physician or family the resident's continued thing and rash, or a reto treat scabies, was not cord. 0 P.M, a skin requested. Resident B is that time. The resident's ted to have a fading rash. If the ght and left arms had the case on them. 1:35 P.M., the DON is not have a specific that or family notification. Inted the facility was in the					
,			1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155520	B. WING		02/05/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
או או אם פ	S NURSING HOME	ПС		RST AVE VILLE, IN 47710	
				VILLE, IIN 4// IU	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	TAG	Bu leuke.	DATE

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155520	B. WING		02/05/2013
NAME OF D	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	ROVIDER OR SUPPLIER	C	909 FI	RST AVE	
BRAUN'S	NURSING HOME	LLC	EVAN	SVILLE, IN 47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0441	483.65				
SS=E	INFECTION CON SPREAD, LINEN	NTROL, PREVENT			
		establish and maintain an			
		Program designed to			
	provide a safe, sa	anitary and comfortable			
		to help prevent the			
	•	I transmission of disease			
	and infection.				
	(a) Infection Cont	trol Program			
		establish an Infection			
	Control Program				
		controls, and prevents			
	infections in the fa	•			
		procedures, such as			
		be applied to an individual			
	resident; and (3) Maintains a re	ecord of incidents and			
	` '	s related to infections.			
	(b) Preventing Sp				
	` '	ection Control Program			
		resident needs isolation to			
	must isolate the r	ad of infection, the facility			
		ust prohibit employees with			
	· '	disease or infected skin			
		ct contact with residents or			
	their food, if direc	ct contact will transmit the			
	disease.				
		ust require staff to wash			
		each direct resident contact			
		ashing is indicated by			
	accepted profess	nonai practice.			
	(c) Linens				
		nandle, store, process and			
	· ·	o as to prevent the spread			
	of infection.		E0.444		00/00/00/0
		ration, interview, and	F0441	Plan of Correction Response	
	record review, th	ne facility failed to		F441 The facility has written	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155520	B. WIN			02/05/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			RST AVE	
BRAUN'S	S NURSING HOME	LLC			VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	develop and imp	lement an Infection			clear and concise Policies and	
	Control program regarding residents and				Procedures to address all area	
	staff with suspected scabies, for 3 of 3				identified under F441. They a	
	residents reviewed who were treated for				identified below: 1. F441 483 a. Infection Control Committee	
		aple of 3. Residents A, B,			Overview; b. Infection Control	
	and C	ipie of 5. Residents 11, B,			Committee – Duties and	
	and C				Responsibilities; c. Develope	d
	Din din an in ala da				responsibilities of proposed	
	Findings include	? :			position "Infection Control	
	1 0 2/5/12 1	0.10.1.1.			Coordinator"; d. Policies and Practices – Infection Control;	• • • • • • • • • • • • • • • • • • •
		10:10 A.M., during			Isolation – Categories of	
		ne Director of Nursing			Transmission – Based	
		cated there had not been			Precautions; f. Isolation –	
	cases of scabies	recently until			Initiating Transmission – Base	d
	approximately 1	/16/13, when a staff			Precautions; g. Communicable/Contagious	
	member was obs	served to have a rash. The			Diseases, Employee; h.	
	staff member inc	dicated a family member			Handwashing/Hand Hygiene;	i.
	had scabies, and	so the DON indicated			Laundry and Bedding, soiled;	• • • • • • • • • • • • • • • • • • •
	she removed the	staff member from the			j. Rash log. (a) Infection Con	• • • • • • • • • • • • • • • • • • •
	schedule, and ga	we her Permethrin cream			Program 1. The infection con	
	_	ntment] for treatment.			committee (ICC) met on Friday February 15, 2103. This	y,
	_	ited she had a "house			committee will meet weekly ur	ntil
		ermethrin cream. The			the entire infection control mar	
		the Medical Director			is reviewed, revised, updated,	
		ff member, and "cleared			implemented, and all staff is	
		work approximately on			thoroughly re-educated. At thi time, the committee will meet a	• • • • • • • • • • • • • • • • • • •
		ON indicated the Medical			minimum of a quarterly schedu	• • • • • • • • • • • • • • • • • • •
					The new position of "Infection	
		ed her to treat any			Control Coordinator" will be	
	_	s in residents or staff with			immediately assumed by the	
	the Permethrin c	ream.			Director of Nursing until those responsibilities are delegated	to a
					current member of the nursing	
	The DON indicated at that time that the				staff or a nurse is hired to	
	1	given her a list of			assume these responsibilities.	
		nd been treated for			2. The Administration has writ	
	scabies. Included	d on the list were			and the ICC has approved the	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLI	ETED
		155520	B. WIN			02/05/2	2013
NAME OF I	DDOWNED OD GUDDI IE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	K		909 FIF	RST AVE		
	S NURSING HOME	ELLC		EVANS	VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	Policies and Practices for		DATE
		and C. The DON			Infection Control, as well as		
	indicated she had inserviced staff				Isolation – Categories of		
		2 weeks prior to come to			Transmission – Based		
		ght they needed treatment,			Precautions. These documen	ts	
	·	ive them the cream. The			provide the Infection Control		
		she had 7 staff members			Coordinator with a standard for the evaluation and determination		
	who requested t	reatment. The DON			of the type of isolation necess	-	
	indicated 1 staff	f member had seen her			to maintain a safe, sanitary an		
	personal physic	ian, and was diagnosed				. At	
	with scabies, bu	t that she found out that			the time of the complaint surve	-	
	information "lat	er." The DON indicated			the Director of Nursing utilized "Infection Log" to record, moni		
	she had not kep	t track of residents or staff			and document corrective action		
	_	scabies in the facility			taken relevant to the infection.		
	^	he DON indicated she			The Administration has opted	to	
	_	ind out when the residents			create a separate log to monit	or	
		d with the Permethrin			any and all rashes to include	.	
	cream.	with the remiethin			scables. This log is completed and in use. (b) Preventing	u	
	Cicaiii.				Spread of Infection 1. At the		
	On 2/5/12 of 11	:15 A.M., CNA # 1			time it is determined that isola	tion	
		ad been treated with the			is the proper nursing intervent	ion,	
					then the Infection Control		
	Permethrin crea				Coordinator shall utilize the "Isolation – Initiating		
		month prior. CNA # 1			Transmission – Based		
		ceived the cream from the			Precaution." As mentioned in	(a)	
	DON.				(2), this document will provide		
					Infection Control Coordinator		
		:20 A.M., during			a standard for the evaluation a determination of placing a	ariu	
	interview with t	he Medical Director, he			resident in isolation. 2. The	e	
		d examined an employee			Administration has written and	-	
	for scabies appr	oximately 2 weeks prior,			ICC has approved the Policy a	and	
after she had been treated for scabies, and she was "clear." The Medical Director				Procedure for			
				Communicable/Contagious Diseases, Employee. The			
	indicated scabies was "very contagious,"				Infection Control Coordinator	will	
		nd staff should be treated if			be able to refer to the standard		
	there was a susp	picious rash. The Medical			and guidelines outlined in this		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	LDING	00	COMPLETED
		155520	B. WIN			02/05/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			RST AVE	
BRALIN'S	NURSING HOME	II C			VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		ed there should have been			policy when determining the no	
	documentation k	tept related to who was			to modify work schedules, ada the environment, and/or restric	
	treated.				an employee's accessibility an	
					contact with the residents. 3.	
	On 2/5/13 at 11:	35 A.M., CNA # 2			The Administration has written	n
		d been treated with the			and the ICC has approved the	
		n for scabies "about 1			Policy and Procedure for	
		iii ioi scables about i			Handwashing/Hand Hygiene.	
	month ago."				This protocol is in place and A	
					staff has been in-serviced. (c)	
	On 2/5/13 at 1:5	5 P.M., the DON			Linens 1. The Administration has written and the ICC has	
	indicated Reside	ent B was treated on			approved the Policy and	
	1/10/13, 1/17/13	and 2/4/13; Residents A			Procedure for Laundry and	
	and C were treat	ed on 2/4/13. The DON			Bedding - Soiled. This protoc	ol
	indicated she det	termined these dates by			is in place and all staff will be	
		she reordered the			in-serviced by Friday, Februar	y
	_	m on 1/10/13. The DON			22, 2013. The Director of	
					Nursing and Environmental	_
		l have a house supply, but			Services Coordinator assumes responsibility for and ensures	
	was running low	, and reordered the			compliance. The Administrator	rie
	cream.				ultimately responsible for over	
					compliance. All Policies and	
	2. On 2/5/13 at 9	9:20 A.M., during the			Procedures identified in 1(a),	
		# 1 indicated she thought			1(b), 1(c), 1(d), 1(e), 1(f), 1(g),	
	•	peen treated for scabies			1(h), 1(i), and 1(j) is completed	
		ident C was not in her			and will be available for review	· 1
	_	e. There was no isolation			the surveyor or survey team up revisit. Compliance Date:	μοιι
					February 22, 2013 March 6,	
		oment in or outside of her			2013 - The Administration will	
	room.				complete the review, editing, a	and
					integrating of the overall Infect	
	On 2/5/13 at 10:	45 A.M., the clinical			Control Policy. Any new or	
	record of Reside	ent C was reviewed.			revised Policies and Procedure	
	Diagnoses included, but were not limited				will be approved by the ICC ar	nd
	_	ocumentation of any rash			staff will be in-serviced	
		itching was not located			accordingly. Margaret H. Braun, HFA Administrator	
	•	_			Braun's Nursing Home	
	in the clinical re	cord. Documentation of a			2.adir o radioning monito	1

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	OF CORRECTION OF CORRECTION 155520	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/05/2013		
	PROVIDER OR SUPPLIER S NURSING HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION		
	physician's order to treat a rash was not in the clinical record. A care plan regarding a rash was not located in the clinical record.					
	On 2/5/13 at 11:15 A.M., a skin assessment was requested. CNA # 1 indicated she had just given the resident a shower that morning, because the resident had the scabies cream applied the night before. Resident C indicated, "It itches." Rash-type areas were observed on the resident's right leg, left arm, and abdomen. The right leg had scabbed areas, where the resident demonstrated she had scratched.					
	3. On 2/5/13 at 9:20 A.M., during the initial tour, LPN # 1 indicated Resident A had been treated for scabies. Resident A was not in her room at that time. There was no isolation precaution equipment in or outside of her room.					
	On 2/5/13 at 9:45 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, senile dementia. Documentation of any rash or complaints of itching was not located in the clinical record. Documentation of a physician's order to treat a rash was not in the clinical record. A care plan regarding a rash was not located in the clinical record.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155520			LDING	NSTRUCTION 00	(X3) DATE COMPL 02/05/	ETED	
	PROVIDER OR SUPPLIER		<u>.</u>	909 FIR	ADDRESS, CITY, STATE, ZIP CODE ST AVE VILLE, IN 47710	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	indicated the itch Resident A indicated abdomen were the itched. Scattered observed on her abdomen. 4. On 2/5/13 at 10 initial tour, LPN had been treated was not in her rowas no isolation or outside of her On 2/5/13 at 10: record of Reside Diagnoses include to, Alzheimer's concerns/Proble Eczema" The most recent alteration in skin P.M., indicated, over D/T [due to [treatment] conts unsuccess [sic]	requested. Resident A ning "comes and goes." rated both of her arms and he main places that rash-type areas were bilateral arms and 9:20 A.M., during the # 1 indicated Resident B for scabies. Resident B for scabies. Resident B for scabies are room. 05 A.M., the clinical first by the scape of the scape					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/05/	ETED
	PROVIDER OR SUPPLIER		P . W.	STREET A	ODDRESS, CITY, STATE, ZIP CODE ST AVE VILLE, IN 47710	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	treat scabies was record.	not in the clinical					
	denied itching at abdomen appears. The resident's rig scabbed-type are indicated at that when the resident She indicated the documentation in regarding treatments. On 2/5/13 at 1 provided the current Infection Control indicated the factor process of revisit policies had been computer." When what the facility Control was prior	that time. The resident's ed to have a fading rash. Ight and left arms had as on them. LPN # 1 time that she was unsure at was treated for scabies. It was treated for scabies. It was not at the clinical record ent. 135 P.M., the DON rent facility policies on 1, undated. The DON illity was currently in the ing the policies, and these in "taken off of the interviewed regarding policy for Infection in to these policies, the					
	DON indicated s from the 80's."	he was using "policies					
	an infection is id Nursing, with the staff and Attendi will confirm that	uded: ociated InfectionsWhen entified, the Director of e input of the nursing ng Physician as needed, the situation meets the fection and will attempt					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/05/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST AVE VILLE, IN 47710	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	CommitteeThe [Infection Control Develop written for the prevention infections among personnelDevelop protocols when of communicable direquired in according [Centers of Disearch and recommendate Practices - Infection objectives of our policies and practices and practices, investigating the facilityE implementing IsoprecautionsMaincidents and coninfections"	cility]Infection Control cobjectives of the IC col] function are to: a. policies and procedures in and control of g residents and clop isolation precaution control of an infectious or isease or disease risk is rdance with CDC ase Control] guidelines ationsPolicies and cion ControlThe confection control citices are to: a. Prevent, i.e., and control infections stablish guidelines for colation					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155520	B. WING		02/05/2013			
NAME OF P	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE				
RDAI INI'S	S NURSING HOME	II.C	909 FIRST AVE EVANSVILLE, IN 47710					
				7 VILLE, IIN 411 IU	(X5)			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE			
1710	REGULATORI GI	CESC IDENTIFY THIS IN CREATION,	1710		BALL			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMI		COMPL	ETED	
		155520	A. BUII B. WIN			02/05/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE		
DDALINIC	NURSING HOME	LLC			VILLE, IN 47710		
BRAUNS	NURSING HOME	LLC		EVAINS	VILLE, IN 477 10		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=E	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE						
	-	maintain clinical records on					
		accordance with accepted dards and practices that					
		curately documented;					
		e; and systematically					
	organized.	-,					
	J						
	The clinical record	d must contain sufficient					
		ntify the resident; a record					
		assessments; the plan of					
		s provided; the results of					
		screening conducted by					
	the State; and pro		F0.5	1.4		_	00/10/0010
		ation, interview, and	F05	14	Plan of Correction Response	tor	02/18/2013
	-	ne facility failed to ensure			F514 The facility has written clear and concise Policies and		
	documentation re	egarding residents' rashes			Procedures to address all area		
	and/or complaint	ts of itching, and			identified under F514. They a		
	treatment provid	ed for suspected scabies,			identified below: 1. F514	-	
	was completely of	documented in the			483.75(I)(1) a. "Policy and		
	clinical record, for	for 3 of 3 residents			Procedure - Change in a Resident's Condition or Status		
	reviewed for con	nplete documentation, in			b. "Policy and Procedure –	•	
		esidents A, B, and C			Charting and Documentation."	C.	
					"Policy and Procedure –		
	Eindings include				Physician Medication Orders."	d.	
	Findings include	·•			"Policy and Procedure –		
	1 On 2/5/13 at 1	0:10 A.M., during			Documentation of Medication/Treatment		
		_			Administration e. "Skin		
		ne Director of Nursing			Assessment(s) – Clinical Proto	col	
		cated there had not been			All professional nursing persor		
	cases of scabies	-			(RN/LPN's) will be in-serviced		
	approximately 1/	/16/13, when a staff			the above referenced policies		
	member was obs	served to have a rash. The			procedures by 7:00 p.m. on		
	DON indicated t	he Medical Director			February 16, 2013. Non nursi	ng	
		treat any suspicious			personnel with responsibilities		
	miorined ner to t	areat arry suspicious			outlined in the "Policy and		

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i i			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPL			COMPLET	ΓED
		155520	B. WIN			02/05/2	013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			RST AVE		
BRAUN'S	NURSING HOME	LLC			SVILLE, IN 47710		
(X4) ID	CLIMMA DV C	TATEMENT OF DEFICIENCIES		ID	·	1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION				COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E '	DATE
TAG				TAG	Procedure – Change in a		DATE
		ts or staff with the			Resident's Condition or Status	,,	
	Permethrin cream.				will be in-serviced before 5:00	,	
					p.m. on February 17, 2013. In		
	The DON indica	ted at that time that the			addition, the Administration ha		
	nurses had just 2	given her a list of			implemented a 24-hour Reside		
	, , ,	d been treated for			Condition Change Sheet. This		
	scabies. Included				form will be maintained by eac	h	
					Charge Nurse and will be		
	Residents A, B,				delivered to the Director of		
	indicated she had not kept track of				Nursing daily. The Director of Nursing will utilize this tool to		
residents or staff with suspected scabies					monitor compliance with		
	in the facility infection log. The DON indicated she would need to find out				notification of changes. The		
					Director of Nursing, or their		
	when the residents had been treated with				designee, will follow-up in each	n	
	the Permethrin c				resident's medical record on a		
		Tourn.			weekly basis for one month, or	n a	
	0 0/5/12 / 11/	20 4 34 1 .			monthly basis for a randomly		
	On 2/5/13 at 11:	. •			selected number from each un	it	
		ne Medical Director, he			for the next quarter, and on a		
	indicated he had	examined an employee			quarterly basis for a randomly selected number from each un	i+	
	for scabies appro	eximately 2 weeks prior,			from this point forward to ensu		
	after she had bee	en treated for scabies, and			that we have notified the reside		
	she was "clear."	The Medical Director			their legal representative or far		
		s was "very contagious,"			member and physician of any		
		d staff should be treated if			change in the resident's medic	al	
					condition and/or status. Week	ly	
	_	icious rash. The Medical			"At Risk" meetings are held to	.	
		ed there should have been			discuss any significant change the resident's medical conditio		
	documentation k	ept related to who was			and/or status. This meeting is	"	
	treated.				attended by the Assessment		
					Coordinator, Social Service		
	On 2/5/13 at 1:5:	5 P.M., the DON			Director, Dietary Manager, Uni	t	
		nt B was treated on			Manager, Director of Nursing,		
		and 2/4/13; Residents A			Administrator. The discussion		
	· ·	ed on 2/4/13. The DON			during this meeting will be utilize	zed	
					as a means of identifying the		
		termined these dates by			medical record of residents for		
	looking at when	she reordered the			audit purposes. At a minimum	,	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		155520	A. BUII		·	02/05/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					RST AVE		
BRAUN'S	S NURSING HOME	LLC		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	Permethrin creat	m on 1/10/13			the Policy and Procedure for		
		III OII 1/10/13.			Charting and Documentation s	shall	
					provide clarity for the following		
	2. On 2/5/13 at 9:20 A.M., during the				a. Documentation Requireme		
	initial tour, LPN	# 1 indicated she thought			b. Who is responsible for		
	Resident C had l	been treated for scabies			recording entries, and c.		
	"last night."				Documentation Criteria The		
	1450 1115110.				Policy and Procedure for		
	0.2/5/12 . 12	45 4 36 41 11 11			Physician Medication Orders		
		45 A.M., the clinical			clearly states that "Medication		
	record of Reside	ent C was reviewed.			shall be administered ONLY u	•	
	Diagnoses include	ded, but were not limited			the written order of a person d	uly	
	to, dementia. Documentation of any rash				licensed and authorized to	L:-	
	or complaints of itching was not located				prescribe such medication in the		
	in the clinical record. Documentation of a				state." Although this policy an procedure addresses additional		
					requirements (i.e. verbal order		
		r to treat a rash was not in			PRN orders, documentation of		
	the clinical recor	rd. A care plan regarding			verbal orders, etc.), the above		
	a rash was not lo	ocated in the clinical			statement is relevant to		
	record.				addressing the non-complianc	e	
					identified in F514. The Policy		
	On 2/5/12 at 11.	15 A.M. o alvin			Procedure for Documentation	of	
	On 2/5/13 at 11:				Medication/Treatment		
		requested. CNA # 1			Administration states "the facil	ity	
	indicated she had	d just given the resident a			shall maintain a medication		
	shower that mor	ning, because the resident			administration record to		
	had the scabies of	cream applied the night			document all		
		C indicated, "It itches."			medication/treatments administered. The document		
		•			provides a clear understanding	n of	
		were observed on the			the following: a. Documentati	•	
	resident's right le	•			of the MAR; b. Documentation		
	abdomen. The ri	ght leg had scabbed			of the TAR; c. Time of	••	
	areas, where the	resident demonstrated			documentation, and d. Minim	um	
	she had scratche	d.			Documentation Requirements		
					order to assure that rashes we		
	On 2/5/13 at 11:	25 A.M. during			not present for residents A, B,	С	
		, ,			and all other residents in the		
		PN # 1, she indicated			facility, the Director of Nursing		
	there should be	documentation in the			conducted a full skin sweep or		
	nurses notes rega	arding the scabies			February 10, 2013. This swee	ep e	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPLETED
		155520	B. WIN			02/05/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	₹			RST AVE	
BRAUN'S	NURSING HOME	IIC			VILLE, IN 47710	
					T	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE
1710		LESC IDENTIFY THAT HAT ORGANIZATION		mo	presented no signs of a rash of	
	treatment.				rashes for any of the residents	
					the building, to include resider	
	3. On 2/5/13 at 9:20 A.M., during the				A, B, and C. The Director of	
	initial tour, LPN	# 1 indicated Resident			Nursing will conduct another for	الد
	A had been treat	ted for scabies.			skin sweep of all residents on	
					February 17, 2013. This swee	
	On 2/5/13 at 9:4	5 A.M., the clinical			will include residents A, B, and This sweep will be completed	
		ent A was reviewed.			10:00 p.m. on the 17th of	Cy
		ded, but were not limited			February. If this sweep does n	ot
	to, senile dementia. Documentation of any rash or complaints of itching was not				produce any concerns, then	
					future sweeps will be conducted	ed
					on an as needed basis. This	
	located in the clinical record.				decision will be based upon information communicated via	tho
		of a physician's order to			24-hour Resident Condition	trie
		not in the clinical record.			Change Sheet, weekly skin	
		rding a rash was not			assessments and documentat	ion,
	located in the cli	inical record.			and the information presented the weekly "At Risk" meeting.	at
	On 2/5/13 at 1:2	0 P M a skin			The Director of Nursing assum	nes
		requested. Resident A			responsibility for and ensures	
		hing "comes and goes."			compliance. The Administrator	
		cated both of her arms and			ultimately responsible for over compliance. All Policies and	all
					Procedures identified in 1(a),	
		he main places that			1(b), 1(c), 1(d) and 1(e) is	
		l rash-type areas were			completed and will be availabl	e
		bilateral arms and			for review by the surveyor or	
	abdomen.				survey team upon revisit. Compliance Date: February 1	8
	4 0 2/5/12 **	0.20 A.M. 1 .: 4			2013 Margaret H. Braun, Hi	• • • • • • • • • • • • • • • • • • •
		9:20 A.M., during the			Administrator Braun's Nursing	
	·	# 1 indicated Resident B			Home	
	had been treated	for scabies.				
	On 2/5/13 at 10·	05 A.M., the clinical				
		ent B was reviewed.				
	_	ded, but were not limited				
	to, Alzheimer's o	aisease.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/05/2013
	PROVIDER OR SUPPLIER		909 FIF	ADDRESS, CITY, STATE, ZIP CODE RST AVE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	.	ed 12/10/12, indicated: ems, Alteration in skin:			
	alteration in skin P.M., indicated, over D/T [due to	nursing note regarding an , dated 12/25/12 at 1:00 "digs [and] scratches all] red rash on body. Tx s [continues] [with]"			
		of a physician's order to not in the clinical			
	denied itching at abdomen appear The resident's rig scabbed-type are indicated at that when the resider She indicated the	requested. Resident B that time. The resident's ed to have a fading rash. ght and left arms had eas on them. LPN # 1 time that she was unsure at was treated for scabies. ere was not in the clinical record			
	interview with the facility did not he documentation p	:55 P.M., during ne DON, she indicated the ave a current policy on rocedures. She indicated currently in the process of licies.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORR		IDENTIFICATION NUMBER: 155520	ILDING NG	00		MPLETED 05/2013
NAME OF PROVIDE			909 FIR	DDRESS, CITY, STATE, Z ST AVE VILLE, IN 47710	IIP CODE	
	ACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
IN00	123348.	relates to Complaint				
3.1-3	0(a)(1)					

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